

111TH CONGRESS
1ST SESSION

H. R. 2369

To improve mental and substance use health care.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 2009

Mr. KENNEDY (for himself and Mrs. BONO MACK) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To improve mental and substance use health care.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; FINDINGS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Improving the Quality of Mental and Substance Use
6 Health Care Act of 2009”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents; findings.

Sec. 2. Evidence-based mental and substance use health care.

Sec. 3. Improved coordination of care.

Sec. 4. Information technology for mental health and substance use health care
providers.

Sec. 5. Council on the Mental Health and Substance Use Health Care Work-
force.

Sec. 6. Funding of research through national centers of excellence.

- Sec. 7. Patient-centered care.
- Sec. 8. Uniform methodologies for reimbursing behavioral health claims.
- Sec. 9. Study on use of public mental health and addiction services by individuals with private health coverage.
- Sec. 10. High-quality mental health and substance use health care Medicaid demonstration project.
- Sec. 11. Medicaid requirement for State repeal of laws denying health benefits coverage based on intoxication.

1 (c) FINDINGS.—The Congress finds the following:

2 (1) In its study, “Improving the Quality of
 3 Health Care for Mental and Substance-Use Condi-
 4 tions”, the Institute of Medicine found that each
 5 year, more than 33,000,000 Americans use health
 6 care services for their mental problems and illnesses,
 7 and for conditions resulting from their use of alco-
 8 hol, inappropriate use of prescription medications,
 9 or, less often, illegal drugs. In the United States,
 10 mental and substance use illnesses (which often
 11 occur together) are the leading cause of death and
 12 disability for women, the highest for men ages 15 to
 13 44, and the second highest for all men.

14 (2) Effective treatments for these medical ill-
 15 nesses exist, but multiple barriers prevent many
 16 from receiving them. The consequences of these bar-
 17 riers are serious for these individuals and their fami-
 18 lies, for their employers and the workforce, for the
 19 Nation’s economy, and for the Nation’s education,
 20 welfare, and justice systems. The Institute of Medi-
 21 cine further found that a comprehensive approach is

1 needed to remedy this issue that addresses the dis-
2 tinguishing characteristics of mental and substance
3 use health care in the United States.

4 (3) The Institute of Medicine recommended a
5 multifaceted and comprehensive strategy to improve
6 the quality of mental and substance use health care
7 in the United States and thereby ensure that—

8 (A) individual patient preferences, needs,
9 and values prevail in the face of residual stig-
10 ma, discrimination, and coercion into treatment;

11 (B) the necessary infrastructure exists to
12 produce scientific evidence more quickly and
13 promote its application in patient care;

14 (C) multiple providers' care of the same
15 patient is coordinated;

16 (D) emerging information technology re-
17 lated to health care benefits people with mental
18 or substance use problems and illnesses;

19 (E) the health care workforce has the edu-
20 cation, training, and capacity to deliver high-
21 quality care for mental and substance use con-
22 ditions; and

23 (F) government programs, employers, and
24 other group purchasers of health care for men-
25 tal and substance use conditions use their dol-

1 lars in ways that support the delivery of high-
2 quality care.

3 (4) To implement this strategy, the Institute of
4 Medicine noted that action is needed from many
5 health care leaders, including the Congress.

6 **SEC. 2. EVIDENCE-BASED MENTAL AND SUBSTANCE USE**
7 **HEALTH CARE.**

8 (a) COMMISSION FOR EVIDENCE-BASED MENTAL
9 AND SUBSTANCE USE HEALTH CARE.—

10 (1) ESTABLISHMENT.—The Secretary of Health
11 and Human Services (in this Act referred to as the
12 “Secretary”) shall establish a Commission for Evi-
13 dence-Based Mental and Substance Use Health Care
14 (in this section referred to as the “Commission”) to
15 strengthen, coordinate, and consolidate the synthesis
16 and dissemination of evidence on effective mental
17 and substance use treatments and services.

18 (2) DUTIES.—For the purposes described in
19 paragraph (1), the Commission shall, on an ongoing
20 basis—

21 (A) identify, describe, and categorize the
22 available evidence-based preventive, diagnostic,
23 and therapeutic interventions (including screen-
24 ing, diagnostic, and symptom-monitoring tools),

1 including interventions for various age and eth-
2 nic groups;

3 (B) recommend procedure and payment
4 codes and definitions for such evidence-based
5 interventions and tools for their use in adminis-
6 trative datasets under part C of title XI of the
7 Social Security Act and recommend standards
8 for health data collection relating to such inter-
9 ventions;

10 (C) identify on an annual basis priority
11 areas for research on—

12 (i) the development of new evidence-
13 based preventive, diagnostic, and thera-
14 peutic interventions;

15 (ii) comparative effectiveness and cost
16 effectiveness of existing interventions and
17 new evidence-based interventions; and

18 (iii) how best to translate new evi-
19 dence-based findings into practice in com-
20 munity-based clinical settings;

21 (D) recommend to the Director of the Na-
22 tional Institute of Mental Health, the Director
23 of the National Institute on Drug Abuse, the
24 Director of the National Institute on Alcohol
25 Abuse and Alcoholism, and other Federal offi-

1 cials methods to coordinate the conduct or sup-
2 port of research described in subparagraph (C);

3 (E) collect, synthesize, and disseminate in-
4 formation on research concerning evidence-
5 based strategies for promoting the use of evi-
6 dence-based preventive, diagnostic, and thera-
7 peutic interventions;

8 (F) provide guidance on effective mental
9 and substance use interventions to Federal
10 agencies that provide or support such interven-
11 tions, including the Centers for Medicare &
12 Medicaid Services, the Substance Abuse and
13 Mental Health Services Administration, the
14 Agency for Healthcare Research and Quality,
15 the Centers for Disease Control and Prevention,
16 the Health Resources and Services Administra-
17 tion, the Department of Defense, the Depart-
18 ment of Veterans Affairs, the Indian Health
19 Service, and the Bureau of Prisons; and

20 (G) periodically assess the progress of
21 agencies described in subparagraph (F) in im-
22 plementing such interventions.

23 (3) CONSULTATION.—In carrying out this sec-
24 tion, the Commission shall—

1 (A) seek consultation from leading public
2 and private State and national authorities, and
3 consolidate evidence, opinions, and findings of
4 these authorities as they see fit; and

5 (B) ensure that interested parties have op-
6 portunities to provide input before the Commis-
7 sion makes recommendations or decisions.

8 (4) MEMBERSHIP.—The Commission shall be
9 composed of not fewer than 15 and not more than
10 20 members, who shall be appointed by the Presi-
11 dent from among experts in evidence-based mental
12 and substance use health care. Such members shall
13 include—

14 (A) researchers;

15 (B) practitioners from various specialties,
16 professions, and practice settings;

17 (C) mental health and substance abuse
18 health care consumers; and

19 (D) health care payers.

20 (5) TERMS.—

21 (A) IN GENERAL.—Each member of the
22 Commission shall be appointed for a term of 4
23 years, except as provided in subparagraphs (B)
24 and (C).

1 (B) TERMS OF INITIAL APPOINTEES.—As
2 designated by the President at the time of ap-
3 pointment, of the members of the Commission
4 first appointed, $\frac{1}{4}$ shall each be appointed for
5 terms of 1, 2, and 3 years and the remainder
6 shall be appointed for a term of 4 years.

7 (C) VACANCIES.—Any member appointed
8 to fill a vacancy occurring before the expiration
9 of the term for which the member's predecessor
10 was appointed shall be appointed only for the
11 remainder of that term. A member may serve
12 after the expiration of that member's term until
13 a successor has taken office.

14 (b) CMS ANNUAL REPORT.—The Administrator of
15 the Centers for Medicare & Medicaid Services shall report
16 annually to the Congress on the extent to which the Med-
17 icaid program under title XIX of the Social Security Act
18 provides coverage of evidence-based interventions identi-
19 fied by the Commission, including—

20 (1) a list of those interventions not so covered
21 and the reasons why they are not covered;

22 (2) a justification for each evidence-based inter-
23 vention that is not so covered; and

24 (3) a list of evidence-based interventions that
25 can be covered only with statutory change.

1 (c) CONSTRUCTION REGARDING APPLICATION.—

2 Nothing in this section shall be construed as requiring,
 3 as a condition of payment under the Medicaid program
 4 under title XIX of the Social Security Act, that an inter-
 5 vention must be an evidence-based practice.

6 (d) PROMPT DEVELOPMENT AND IMPLEMENTATION

7 OF CLAIMS PROCESSING AND DATA CODES.—The Sec-
 8 retary, acting through the Administrator of the Centers
 9 for Medicare & Medicaid Services, shall establish, or enter
 10 into an agreement with, one or more entities for the pur-
 11 pose of developing, as soon as practicable after the date
 12 of the enactment of this Act, codes that should be applied
 13 to claims processing and health data collection activities
 14 as recommended by the Commission pursuant to sub-
 15 section (a)(2)(B).

16 (e) DEFINITION.—In this section, the term “interven-
 17 tion” means a preventive, diagnostic, or therapeutic action
 18 with respect to a mental health or substance use disease
 19 process.

20 **SEC. 3. IMPROVED COORDINATION OF CARE.**

21 (a) INTERAGENCY COLLABORATIVE GROUP.—

22 (1) ESTABLISHMENT.—The Secretary shall con-
 23 vene an interagency collaborative group (in this sec-
 24 tion referred to as the “interagency collaborative
 25 group”) to provide for the coordination at the clin-

1 ical and programmatic level of mental health and
2 substance use services and primary care services,
3 funded in whole or in part through the Department
4 of Health and Human Services, the Department of
5 Justice, the Department of Veterans Affairs, the De-
6 partment of Defense, and the Department of Edu-
7 cation, using one or more evidence-based coordina-
8 tion models, such as the following:

9 (A) Formal agreements between mental
10 health, substance use, and primary care pro-
11 viders.

12 (B) Case management of mental health,
13 substance use, and primary care.

14 (C) Co-location of mental health, substance
15 use, and primary care providers.

16 (D) Delivery of mental health, substance
17 use, and primary care in integrated practices.

18 (2) DUTIES.—The interagency collaborative
19 group shall—

20 (A) develop a plan for government agencies
21 to implement the recommendations made by the
22 Commission for Evidence-Based Mental and
23 Substance Use Health Care;

1 (B) coordinate with States and appropriate
2 public stakeholders to foster interagency col-
3 laboration at the State and local level;

4 (C) make recommendations to the Presi-
5 dent and the Congress to break down barriers
6 to coordination of existing Federal programs
7 funding mental health and substance use serv-
8 ices and to allow for more effective integration
9 of such programs across agencies and pro-
10 grams;

11 (D) assess progress toward such coordina-
12 tion through development and monitoring of
13 performance measures of coordination; and

14 (E) report to the Congress biannually on
15 the status of such coordination.

16 (3) COMPOSITION.—The interagency collabo-
17 rative group shall include the following members:

18 (A) The Secretary of Health and Human
19 Services (or the Secretary's designee).

20 (B) The Attorney General (or the Attorney
21 General's designee).

22 (C) The Secretary of Veterans Affairs (or
23 such Secretary's designee).

24 (D) The Secretary of Defense (or such
25 Secretary's designee).

1 (E) The Secretary of Education (or such
2 Secretary's designee).

3 (4) MEETINGS.—The interagency collaborative
4 group shall meet not less than quarterly.

5 (5) STAFF AND SUPPORT.—The Secretary shall
6 provide, without the requirement for reimbursement,
7 staff and other administrative support necessary for
8 the operation of the interagency collaborative group.

9 (b) COORDINATED DELIVERY OF CARE.—The Fed-
10 eral agencies participating in the interagency collaborative
11 group shall modify internal policies and practices, to the
12 extent practicable and consistent with legal authority, in
13 order to implement one or more of the evidence-based co-
14 ordination models referred to in subsection (a)(1).

15 (c) NO EFFECT ON HIPAA PRIVACY RULES.—Noth-
16 ing in this section shall be construed to alter the applica-
17 tion of rules promulgated under section 264(c) of the
18 Health Insurance Portability and Accountability Act of
19 1996.

20 (d) GAO REPORT.—Not later than 2 years after the
21 date of the enactment of this Act, the Comptroller General
22 of the United States shall conduct a study and submit a
23 report to the Congress on the implementation of this sec-
24 tion.

1 (e) CLARIFICATION OF MEDICAID REIMBURSEMENT
2 OPTIONS.—The Secretary shall provide, by regulation, for
3 a change in the rules under title XIX of the Social Secu-
4 rity Act relating to reimbursement for primary care serv-
5 ices and mental health and substance use services to the
6 same patient on the same day so as to permit payment
7 for the legitimate provisions of both types of services on
8 the same day to a patient.

9 **SEC. 4. INFORMATION TECHNOLOGY FOR MENTAL HEALTH**
10 **AND SUBSTANCE USE HEALTH CARE PRO-**
11 **VIDERS.**

12 (a) DEVELOPMENT AND IMPLEMENTATION OF
13 PLAN.—The Secretary, acting through the National Coor-
14 dinator for Health Information Technology and the Ad-
15 ministrator of the Substance Abuse and Mental Health
16 Services Administration, shall develop and implement a
17 plan for ensuring that activities of the Department of
18 Health and Human Services to promote the use of infor-
19 mation technology by health care providers include pro-
20 motion of information technology that is accessible and
21 pertinent to mental health and substance use health care
22 providers and consumers.

23 (b) CONTENTS OF PLAN.—The plan developed under
24 subsection (a) shall address—

1 (1) how the development of an electronic health
2 information infrastructure, including the awarding
3 of grants and contracts to promote the use of elec-
4 tronic health records (EHRs), personal health
5 records (PHRs), regional health information organi-
6 zations (RHIOs), and other forms of health informa-
7 tion technology, and the establishment of data
8 standards, will ensure that the needs of mental and
9 substance use health care providers and consumers
10 are met with particular emphasis on the privacy con-
11 cerns of consumers;

12 (2) how financial incentives that are generally
13 made available for the development of such infra-
14 structure for health care providers can be provided
15 to individual mental health and substance use clini-
16 cians and organizations (and particularly publicly-
17 funded providers) for investments in information
18 technology to enable them to participate on a full
19 and equal basis in the emerging electronic health in-
20 frastructure;

21 (3) how any continuing technical assistance and
22 training for developing virtual networks may be
23 made available to give individual and small group
24 providers of mental health and substance use serv-
25 ices standard access to software, clinical and popu-

1 lation data and health records, and billing and clin-
2 ical decision-support systems; and

3 (4) how to create and support a continuing
4 mechanism to engage mental health and substance
5 use stakeholders in the public and private sectors in
6 developing consensus-based recommendations for
7 data elements, standards, and processes needed to
8 address unique aspects of information management
9 related to mental and substance use healthcare.

10 (c) CONSIDERATION.—In awarding any grant or con-
11 tract for the development or implementation of any com-
12 ponent of a national electronic health infrastructure, the
13 Secretary shall consider the application of such component
14 to mental health and substance use health care and pro-
15 viders of such care.

16 (d) CONTINUED PRIVACY PROTECTIONS.—In devel-
17 oping or promoting the national electronic health infra-
18 structure, the Secretary shall ensure that privacy and con-
19 fidentiality requirements traditionally applicable to mental
20 health and substance use health care continue to be ap-
21 plied.

22 (e) INCLUSION OF INFORMATION IN REPORTS.—In
23 preparing any report to the Congress relating to the devel-
24 opment or implementation of a national electronic health
25 infrastructure or the promotion of the use of health infor-

1 mation technology, the Secretary shall include information
2 on such development, implementation, or promotion in the
3 field of mental health and substance use treatment.

4 **SEC. 5. COUNCIL ON THE MENTAL HEALTH AND SUB-**
5 **STANCE USE HEALTH CARE WORKFORCE.**

6 (a) ESTABLISHMENT.—The Secretary shall establish
7 a public-private advisory group called the Council on the
8 Mental Health and Substance Use Health Care Workforce
9 (in this section referred to as the “Council”).

10 (b) DUTIES.—

11 (1) DEVELOPMENT OF COMPREHENSIVE
12 PLAN.—The Council shall develop and publish a
13 comprehensive plan for purpose of strengthening the
14 capacity of the workforce to deliver high-quality
15 mental health and substance use health care.

16 (2) PLAN CONTENTS.—The plan developed
17 under this subsection shall—

18 (A) identify the specific clinical com-
19 petencies that all mental health and substance
20 use professionals should possess to be certified
21 or licensed and the competencies, including a
22 component of patient centered care, that should
23 be maintained over time;

24 (B) identify the specific mental health and
25 substance use education that should be required

1 of health care professionals and integrated into
2 the medical education and training of all health
3 care professionals;

4 (C) propose national standards for the
5 credentialing and licensure of mental health and
6 substance use health care providers based on
7 core competencies that should be included in
8 curricula and education programs across all the
9 mental health and substance use disciplines and
10 make recommendations regarding accreditation
11 standards for mental health and substance use
12 health care programs;

13 (D) propose programs for funding from
14 Federal, State, and local governments and the
15 private sector to address and resolve long-
16 standing workforce issues such as diversity, cul-
17 tural relevance, faculty development, training
18 effectiveness, continuing shortages of well-
19 trained clinicians needed to work with children
20 and the elderly and in high-need areas, and pro-
21 grams for training competent clinical super-
22 visors and administrators; and

23 (E) provide for continuing assessment of
24 mental health and substance use workforce
25 trends, issues, and financing policies.

1 (3) EVALUATION; REPORTING.—On a biannual
2 basis, the Council shall—

3 (A) conduct an evaluation of the extent to
4 which the purpose specified in paragraph (1)
5 has been met; and

6 (B) submit a report to the Congress on the
7 results of such evaluation, including a descrip-
8 tion of the status of the mental health and sub-
9 stance use health care workforce.

10 (4) ASSISTANCE.—The Council shall collaborate
11 with private sector coalitions to facilitate and imple-
12 ment its recommendations.

13 (c) MEMBERSHIP.—

14 (1) NUMBER; APPOINTMENT; CHAIR.—The
15 Council shall be composed of not less than 21 and
16 not more than 25 individuals appointed by the Sec-
17 retary. The Council shall elect a chair from among
18 its members.

19 (2) PUBLIC SECTOR MEMBERS.—The Council
20 shall include the following officials (or their des-
21 ignees):

22 (A) The Assistant Secretary for Health in
23 the Department of Health and Human Services.

24 (B) The Administrator of the Centers for
25 Medicare & Medicaid Services.

1 (C) The Administrator of the Substance
2 Abuse and Mental Health Services Administra-
3 tion.

4 (D) The Secretary of Veterans Affairs.

5 (3) PRIVATE SECTOR MEMBERS.—The Council
6 shall include representatives from the substance use
7 and mental health services and consumer commu-
8 nities who are not employees of the Federal Govern-
9 ment. Such representatives shall be appointed by the
10 Secretary without regard to the Federal civil service
11 laws and shall include the following:

12 (A) One individual selected from full-time
13 students enrolled in mental health training pro-
14 grams.

15 (B) One individual selected from full-time
16 students enrolled in substance use health care
17 training programs.

18 (C) One individual selected from mental
19 health consumers.

20 (D) One individual selected from substance
21 use health care consumers.

22 (E) One individual selected from faculty
23 members at mental health training facilities.

1 (F) One individual selected from faculty
2 members at substance use health care training
3 facilities.

4 (G) Five individuals selected from among
5 leading professional associations in the various
6 fields charged with carrying out mental health
7 and substance use services, including psychi-
8 atry, addiction medicine, psychology, social
9 work, psychiatric nursing, counseling, marriage
10 and family therapy, pastoral counseling, psycho-
11 social rehabilitation, and substance use treat-
12 ment counselors.

13 (H) Five individuals selected from among
14 leading professional licensing and credentialing
15 entities in the various fields charged with car-
16 rying out mental health and substance use serv-
17 ices including psychiatry, addiction medicine,
18 psychology, social work, psychiatric nursing,
19 counseling, marriage and family therapy, pas-
20 toral counseling, psychosocial rehabilitation,
21 and substance use treatment counseling.

22 (4) SELECTION.—In selecting the members of
23 the Council under paragraph (3), the Secretary shall
24 ensure—

1 (A) the inclusion of both urban and rural
2 members;

3 (B) a range of members from a variety of
4 practice settings and including expertise in pre-
5 vention and treatment across the lifespan;

6 (C) adequate representation of racial, eth-
7 nic, religious, and economic diversity in its
8 membership; and

9 (D) the members appointed under sub-
10 paragraphs (G) and (H) of paragraph (3) are
11 equitably distributed between those specializing
12 in mental health services and those specializing
13 in substance use services.

14 (5) TERMS.—

15 (A) IN GENERAL.—Each member of the
16 Council under paragraph (3) shall be appointed
17 for a term of 4 years, except that except as pro-
18 vided in subparagraphs (B) and (C).

19 (B) TERMS OF INITIAL APPOINTEES.—As
20 designated by the Secretary at the time of ap-
21 pointment, of the members of the Council first
22 appointed under paragraph (3), $\frac{1}{4}$ shall each
23 be appointed for terms of 1, 2, and 3 years and
24 the remainder shall be appointed for a term of
25 4 years.

1 (C) VACANCIES.—Any member appointed
2 under paragraph (3) to fill a vacancy occurring
3 before the expiration of the term for which the
4 member’s predecessor was appointed shall be
5 appointed only for the remainder of that term.
6 A member may serve after the expiration of
7 that member’s term until a successor has taken
8 office.

9 (d) MEETINGS.—The Council shall conduct at least
10 3 meetings each year.

11 (e) STAFF AND SUPPORT.—The Secretary shall pro-
12 vide, without the requirement for reimbursement, staff
13 and other administrative support necessary for the oper-
14 ation of the Council.

15 **SEC. 6. FUNDING OF RESEARCH THROUGH NATIONAL CEN-**
16 **TERS OF EXCELLENCE.**

17 (a) GRANTS.—The Director of the National Insti-
18 tutes of Health (in this section referred to as the “Direc-
19 tor of NIH”), acting through the Directors of the National
20 Institute of Mental Health, the National Institute of Drug
21 Abuse, and the National Institute on Alcohol Abuse and
22 Alcoholism, and in consultation with the Administrator of
23 the Substance Abuse and Mental Health Services Admin-
24 istration, shall make grants to entities to fund a network

1 of national centers of excellence in mental health and sub-
2 stance use health care.

3 (b) USE OF FUNDS.—As a condition on receipt of
4 a grant under this section, an entity shall agree to use
5 the grant to establish or support one or more centers of
6 excellence in mental health and substance use health care.
7 Each such center shall—

8 (1) integrate basic, clinical, or health services
9 research with interventions in a range of usual set-
10 tings of care delivery and involve a broad cross-sec-
11 tion of mental health and substance use health care
12 stakeholders; and

13 (2) develop innovative approaches to tie to-
14 gether research and practice in order to develop a
15 research agenda relevant to providers of mental
16 health and substance use health care services in a
17 range of usual settings of care.

18 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 \$10,000,000 for fiscal year 2011, \$15,000,000 for fiscal
21 year 2012, \$20,000,000 for fiscal year 2013, \$25,000,000
22 for fiscal year 2014, and such sums as may be necessary
23 for each subsequent fiscal year.

1 **SEC. 7. PATIENT-CENTERED CARE.**

2 (a) PROMOTION IN FEDERAL PROGRAMS.—With re-
3 spect to any program that provides for the Department
4 of Health and Human Services, the Department of Jus-
5 tice, the Department of Veterans Affairs, Department of
6 Defense, or the Department of Education to pay for or
7 provide mental health and substance use care, each such
8 Department shall provide for the following:

9 (1) Within the authority of the Department
10 with respect to such program—

11 (A) include payment for, or provision of,
12 peer support and illness self-management pro-
13 grams that meet evidence-based standards for
14 individuals with chronic mental illnesses or sub-
15 stance use dependence; and

16 (B) provide for appropriate payment and
17 coverage reforms, such as the application of co-
18 payments, service exclusions, and benefit limits,
19 so as to eliminate barriers to the effective, ap-
20 propriate, and evidence-based provision of such
21 care.

22 (2) Endeavor to make reliable comparative in-
23 formation on the quality of such care provided by
24 practitioners and organizations available to con-
25 sumers and to encourage consumers to use this in-

1 formation when making decisions about from whom
2 to receive such care.

3 (3) Insofar as the Department does not have
4 authority described in paragraph (1), make rec-
5 ommendations to the Congress regarding changes in
6 law to provide for such authority.

7 (b) SENSE OF CONGRESS FOR ALL PROGRAMS.—It
8 is the sense of the Congress that clinicians and organiza-
9 tions providing mental health and substance use treatment
10 services should—

11 (1) incorporate, consistent with applicable State
12 laws, informed, patient-centered decisionmaking and
13 (for children) informed family decisionmaking
14 throughout their practices, including active patient
15 participation in the design and revision of the pa-
16 tient treatment and recovery plans, psychiatric ad-
17 vance directives, and provision of information on the
18 availability and effectiveness of mental health and
19 substance use treatment options;

20 (2) adopt recovery-oriented and illness self-
21 management practices that support patient pref-
22 erence for treatment (including medications), peer
23 support, and other elements of the wellness recovery
24 plan; and

1 (3) maintain effective, formal linkages with
2 community resources to support patient illness self-
3 management and recovery.

4 **SEC. 8. UNIFORM METHODOLOGIES FOR REIMBURSING BE-**
5 **HAVIORAL HEALTH CLAIMS.**

6 (a) IN GENERAL.—The Secretary, through the work-
7 ing group convened under subsection (b), shall develop
8 uniform methodologies across geographic areas and types
9 of payers for the following with respect to medical assist-
10 ance, related services, and administrative costs furnished
11 to individuals with mental illnesses and substance use dis-
12 orders in both community-based and residential settings:

13 (1) Qualifications for eligibility for payment.

14 (2) Financial auditing.

15 (3) Claims payment (including billing codes).

16 (b) CONVENING OF WORKING GROUP.—The Sec-
17 retary shall carry out subsection (a) by convening a work-
18 ing group is composed of the Directors and Administrators
19 of all relevant agencies, including the Centers for Medicare
20 & Medicaid Services, the Office of Management and Budg-
21 et, the Health Resources and Services Administration, the
22 Substance Abuse and Mental Health Services Administra-
23 tion, the office of the Inspector General of the Department
24 of Health and Human Services, acting jointly with State

1 Medicaid directors and other State, local, and private
2 healthcare payers.

3 (c) REQUIREMENTS.—The methodology developed
4 under subsection (a)—

5 (1) shall not result in new medical necessity cri-
6 teria, and shall not prohibit or restrict payment for
7 medical assistance, related services, and administra-
8 tive activities under title XIX of the Social Security
9 Act that are provided or conducted in accordance
10 with options under such title regarding targeted case
11 management, rehabilitative services, or clinical serv-
12 ices; and

13 (2) with respect to administrative costs, shall be
14 based on—

15 (A) standards related to time studies and
16 populations estimates; and

17 (B) a national standard for determining
18 payment of such costs.

19 (d) RULE OF CONSTRUCTION.—Nothing in this sec-
20 tion shall be construed as requiring, as a condition of pay-
21 ment under the Medicaid program under title XIX of the
22 Social Security Act, that an intervention must be an evi-
23 dence-based practice.

1 **SEC. 9. STUDY ON USE OF PUBLIC MENTAL HEALTH AND**
2 **ADDICTION SERVICES BY INDIVIDUALS WITH**
3 **PRIVATE HEALTH COVERAGE.**

4 (a) IN GENERAL.—The Comptroller General of the
5 United States shall conduct a study on the use of publicly
6 supported mental health and addiction services by individ-
7 uals who have any level of private health insurance cov-
8 erage.

9 (b) REPORT.—The Comptroller General shall submit
10 to the Congress a report on the study under subsection
11 (a). The report shall include a description of—

12 (1) the number of individuals described in sub-
13 section (a);

14 (2) the types of private health insurance cov-
15 erage involved; and

16 (3) the public programs providing the mental
17 health and addiction services involved and the cost
18 of such services provided.

19 **SEC. 10. HIGH-QUALITY MENTAL HEALTH AND SUBSTANCE**
20 **USE HEALTH CARE MEDICAID DEMONSTRA-**
21 **TION PROJECT.**

22 (a) IN GENERAL.—The Secretary shall establish a 5-
23 year demonstration project (in this section referred to as
24 the “project”) designed to demonstrate the impact of cre-
25 ating delivery and financing structures that deliver high-
26 quality, integrated mental health and substance use health

1 care. Such project shall be based upon the report of the
2 Institute of Medicine (of November 2005) relating to Im-
3 proving the Quality of Health Care for Mental and Sub-
4 stance-Use Conditions: Quality Chasm Series, and shall
5 include demonstrating at least the following:

6 (1) Coordinated delivery of mental health, sub-
7 stance use, and primary health care, utilizing a co-
8 location or integrated delivery model.

9 (2) Use of evidence-based practices, to as great
10 an extent as possible.

11 (3) Provision of patient-centered care that em-
12 phasizes recovery-oriented practices and informed
13 patients and, where appropriate, family decision-
14 making.

15 (4) A commitment to utilizing health informa-
16 tion technology to improve the quality and efficiency
17 of care.

18 (b) REQUIRED REPORTING ON QUALITY.—The Sec-
19 retary shall provide that each health care provider partici-
20 pating in the project shall submit data on quality meas-
21 ures determined by the Secretary.

22 (c) WAIVER OF REQUIREMENTS.—

23 (1) IN GENERAL.—Subject to paragraph (2),
24 the Secretary is authorized to waive such require-
25 ments of title XIX of the Social Security Act, such

1 as statewideness, a limitation on the scope of serv-
2 ices included in medical assistance, and the coverage
3 of additional administrative expenses, as may be
4 necessary for the implementation of the project.

5 (2) LIMITATION ON FUNDING.—The Secretary
6 shall design the project in such a manner so that the
7 net additional Federal expenditures under title XIX
8 of the Social Security Act resulting from the project
9 does not exceed \$50,000,000.

10 (d) INDEPENDENT EVALUATION.—The Secretary
11 shall provide for an independent evaluation of activities
12 provided under the project, in comparison with a control
13 group. Such evaluation shall include an assessment of
14 health and social outcomes for beneficiary participants,
15 such as employment status, receipt of welfare benefits,
16 criminal justice contacts, and homelessness, as well as the
17 resource utilization for medical services, mental and sub-
18 stance use health care, and social services. Such evaluation
19 shall also include an assessment of the impact of activities
20 provided under the project on workforce recruitment and
21 retention.

22 (e) REPORTS TO CONGRESS.—

23 (1) INTERIM REPORT.—Not later than 2 years
24 after the initiation of the project, the Secretary shall
25 submit to the Congress an interim report on the

1 project. Such report shall include such recommenda-
 2 tions as the Secretary determines appropriate.

3 (2) FINAL REPORT.—Not later than 1 year
 4 after the completion of the project, the Secretary
 5 shall submit to the Congress a final report on the
 6 project. The report shall include the results of the
 7 independent evaluation provided under subsection
 8 (d) as well as recommendations regarding redesign
 9 of the mental health and substance use benefit
 10 under the Medicaid program to maximize the quality
 11 and efficiency of such benefits.

12 **SEC. 11. MEDICAID REQUIREMENT FOR STATE REPEAL OF**
 13 **LAWS DENYING HEALTH BENEFITS COV-**
 14 **ERAGE BASED ON INTOXICATION.**

15 (a) IN GENERAL.—Section 1902 of the Social Secu-
 16 rity Act (42 U.S.C. 1396a), as amended by section 5006
 17 of division B of Public Law 111–5, is amended—

18 (1) in subsection (a)—

19 (A) by striking “and” at the end of para-
 20 graph (72);

21 (B) by striking the period at the end of
 22 paragraph (73) and inserting “; and”; and

23 (C) by inserting after paragraph (73) the
 24 following new paragraph:

1 “(74) provide that the State has in effect a law
 2 that requires any insurance contract covering med-
 3 ical care losses in the group and individual market
 4 that is to be offered in the State to meet the re-
 5 quirements of subsection (gg)(1).”; and

6 (2) by adding at the end the following new sub-
 7 section:

8 “(gg) REQUIREMENTS FOR INSURANCE COVERING
 9 MEDICAL LOSSES IN THE GROUP AND INDIVIDUAL MAR-
 10 KET.—

11 “(1) RESTRICTIONS ON EXCLUSIONS AND LIMI-
 12 TATIONS RELATING TO INTOXICATION.—The re-
 13 quirements of this paragraph with respect to insur-
 14 ance contracts covering medical care losses in the
 15 group and individual market are as follows:

16 “(A) A prohibition against the exclusion or
 17 denial of covered services and benefits, in con-
 18 nection with the treatment of any patient whose
 19 medical condition, illness, or injury, involves
 20 confirmed or suspected intoxication as a result
 21 of alcohol or other substance.

22 “(B) A prohibition against discrimination
 23 against health care providers in the rate or level
 24 of payment for covered services in cases in

1 which intoxication is either suspected or con-
2 firmed.

3 “(C) An express obligation to provide and
4 pay for covered services and treatments nec-
5 essary to the treatment of any condition, illness,
6 or injury without regard to whether intoxication
7 is either suspected or confirmed.

8 “(D) An express obligation to cooperate
9 with the state agency for medical assistance as
10 provided under section 1902(a)(25).

11 “(2) INCLUSION OF ALL FORMS OF COV-
12 ERAGE.—For purposes of subsection (a)(74) and
13 paragraph (1), the term ‘insurance contract covering
14 medical care losses in the group and individual mar-
15 ket’ includes any class or type of insurance relating
16 to medical care in the group or individual market,
17 including plans covering public employees as well as
18 private employees, regardless of whether coverage
19 under the contract is expressed in terms of defined
20 benefits or defined cash contributions toward the
21 cost of medical losses.”.

22 (b) EFFECTIVE DATE.—

23 (1) Except as provided in paragraph (2), the
24 amendments made by subsection (a) shall apply to
25 calendar quarters beginning on or after January 1,

1 2010, without regard to whether or not final regula-
2 tions to carry out such amendments have been pro-
3 mulgated by such date.

4 (2) In the case of a State plan for medical as-
5 sistance under title XIX of the Social Security Act
6 which the Secretary determines requires State legis-
7 lation (other than legislation appropriating funds) in
8 order for the plan to meet the additional require-
9 ments imposed by the amendments made by sub-
10 section (a), the State plan shall not be regarded as
11 failing to comply with the requirements of such title
12 solely on the basis of its failure to meet these addi-
13 tional requirements before the first day of the first
14 calendar quarter beginning after the close of the
15 first regular session of the State legislature that be-
16 gins after the date of the enactment of this Act. For
17 purposes of the previous sentence, in the case of a
18 State that has a 2-year legislative session, each year
19 of such session shall be deemed to be a separate reg-
20 ular session of the State legislature.

○